MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
HEALTH FACILITY REGULATION

APPLICATION FOR AMBULATORY SURGICAL CENTER LICENSE

Print Reset

P.O. BOX 570
JEFFERSON CITY, MISSOURI 65102-0570
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If you make any changes (days/hours of operation, administrator, ownership, or types of procedures) please contact our office.

☐ INITIAL APPLICATION ☐ RENEWAL APPLICATION ☐ CHANGE

Application to operate an ASC as defined by Sec. 197.200(1), RSMo and 19 CSR 30-30.010(1)(b), and in compliance with Secs. 197.200- 197.240, RSMo and 19 CSR 30-30.020-19 CSR 30-30.040.

DO NOT WRITE IN THIS SPACE

LICENSE NO.
LICENSE DATE
CERTIFICATE NO.
ISSUE DATE

NAME OF FACILITY (NAME TO APPEAR ON LICENSE)	TELEPHONE NO.

STREET ADDRESS	CITY & ZIP CODE	COUNTY

ADMINISTRATOR	EMAIL
BEST FACILITY CONTACT NAME	EMAIL

MANAGEMENT

NON PROFIT
- ☐ CORPORATION
- ☐ OTHER (SPECIFY)

PROPRIETARY
- ☐ INDIVIDUAL
- ☐ PARTNERSHIP
- ☐ CORPORATION
- ☐ OTHER (EXPLAIN)

CHIEF OFFICER OF GOVERNING BODY	LEGAL NAME OF OPERATING CORPORATION

IF OPERATED BY MANAGEMENT CONSULTANT, NAME OF FIRM

CREDENTIALED STAFF

TOTAL	MD/DO	DENTISTS
PODIATRISTS	ANESTHESIOLOGISTS	CRNAS

SPECIALTY (INCLUDE ALL THAT APPLY)

- ☐ GENERAL
- ☐ PLASTIC/COSMETIC
- ☐ ENDOSCOPY
- ☐ ORTHOPEDIC
- ☐ EYES
- ☐ OTHER (EXPLAIN BELOW)

AVERAGE PROCEDURES PERFORMED PER MONTH	TOTAL PROCEDURES PERFORMED IN THE LAST YEAR	INDICATE PRIMARY SURGERY/PROCEDURE PERFORMED

ROUTINE DAYS/HOURS OPEN FOR NORMAL BUSINESS: (M-F, 8A-6P, ETC.)	TYPICAL PROCEDURE/SURGERY SCHEDULE (*IF DIFFERENT*)

DOES THE FACILITY HAVE A TRANSFER AGREEMENT WITH LOCAL HOSPITAL? ☐ YES ☐ NO

NUMBER OF OPERATING ROOMS	NUMBER OF PROCEDURE ROOMS

NATIONAL PROVIDER IDENTIFIER # (NPI)

ACCREDITATION/DEEMED STATUS (IF YOUR FACILITY IS ACCREDITED, ATTACH THE MOST RECENT CORRESPONDENCE/REPORT FROM YOUR ACCREDITING ORGANIZATION INDICATING STATUS)

☐ ACCREDITED ☐ DEEMED	NAME OF ACCREDITING ORGANIZATION

ATTACH AN ORGANIZATION CHART INDICATING OWNERSHIP AND/OR CONTROL. ATTACH SEPARATELY.

CERTIFICATION

We the undersigned hereby certify that we have read the foregoing application and the statements contained therein are true and correct to the best of our knowledge, and further assure the ability and intention of the _____ FACILITY NAME to comply with Missouri statutes and regulations pertaining to ambulatory surgery licensure.

CHIEF EXECUTIVE OFFICER SIGNATURE	PRINT NAME	DATE
CHAIR OF GOVERNING BODY SIGNATURE	PRINT NAME	DATE
ADMINISTRATOR SIGNATURE	PRINT NAME	DATE